NEBRASKA NEWBORN SCREENING PROGRAM
NEWBORN TRANSFER FORM

Date of Transfer: _____

Person Completing Form: _____

Hospital of Birth: _____

Infant's Name: _____

Date of Birth: _____ Time of Birth: _____

Date of Specimen Collection:_____ Time of Specimen Collection:_____

Transferring Physician: _____

Newborn Screening Specimen Collected at Hospital of Birth: Yes No

Newborn Screening Specimen Collected Prior to 24 Hours of Age: Yes No

Infant transfused? Yes No

If yes, was specimen collected prior to transfusion? Yes No

If collected post-transfusion, indicate type: _____ and time of transfusion ___:___

Receiving Hospital: _____

Receiving Physician: _____

Person Receiving Form: _____

ATTENTION RECEIVING PHYSICIAN: If the newborn screening tests have not been performed or tests need to be repeated when you take charge of the infant, you are responsible for ordering a specimen and returning the results recorded on this form and the hospital of birth.

Forward one copy of this form to the receiving hospital and **fax** one copy to:

Nebraska Newborn Screening Program
Department of Health & Human Services
402 471-1863